

FIELD TRIP MEDICAL INFORMATION

Student Name: _____ Age: _____ DOB: _____

Address: _____ City _____ State _____ Zip _____

Name of Parent/Guardian: _____

Home Phone: _____ Work Phone _____ Cell Phone _____

Family Physician _____ Phone _____

In case of emergency, notify the following if a parent cannot be reached:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Insurance Information (required): Company _____

Policy Holder: _____ Policy Number _____

Recent illnesses: _____

Allergies: _____

Dietary Restrictions: _____

Activity restrictions or other health concerns: _____

Current Medications	Dosage	Time(s) Given
_____	_____	_____
_____	_____	_____

Place all medications, in their original container, into a zip lock bag and label with name, school, and grade. All medications should stay in the possession of the chaperone, except for those with self-medicate and self-monitor agreements on file with the school. Send only the amount of medication needed during the trip.

Place a check beside each over-the-counter medication we may administer to your child.

Ibuprofen Tylenol Milk of Magnesia Midol/Pamprin
 Benedryl Neosporin Dramamine Other _____

I give permission to the physician or hospital to secure proper treatment for and to order medications, injections, anesthesia, and/or surgery for my child as named above.

Signature of Parent/Guardian Date Signed Relationship